TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
OrthoTexas Physicians and Surgeons

Respondent Name
Lewisville ISD

MFDR Tracking Number
M4-17-3749-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 21, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… this claim was denied stating "non-covered". Per Rule 134.120(f)(5)(A), this causation letter that was requested by OIEC should be reimbursed at $100.00."

Amount in Dispute: $100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "OIEC requested the medical opinion, the respondent maintains that OIEC's letter does not constitute a request from the division per 28 Texas Administrative Code §134.120(e) and is not reimbursable."

Response Submitted by: Starr Comprehensive Solutions

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 25 and May 23, 2017	Medical Narrative (99080)	$100.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
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3. 28 Texas Administrative Code §134.120 sets out the procedures and reimbursement for medical documentation.
4. Texas Labor Code §404.002 establishes the Office of Injured Employee Counsel administrative attachment.
5. Texas Labor Code §404.101 defines the general duties of the Office of Injured Employee Counsel.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 96 – Non-covered charge(s).
   - Comments: "The narrative report was provided to the OIEC and not the TDI-DWC or the carrier: therefore, this is a non-covered charge."
   - W3 – Additional reimbursement made on reconsideration.
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.

Issues

Is Lewisville ISD responsible for reimbursement of the service in question?

Findings

OrthoTexas Physicians and Surgeons is seeking reimbursement of $100.00 for medical narratives provided on April 25 and May 23, 2017. Reimbursement of medical narratives is subject to the requirements of 28 Texas Administrative Code §134.120, which states, in relevant part, "(d) If the injured employee, or the injured employee's representative, requests creation of medical documentation, such as a medical narrative, the requestor shall reimburse the health care provider for this additional information."

OrthoTexas Physicians and Surgeons argued that the medical narrative was requested by the Office of Injured Employee Counsel (OIEC). Texas Labor Code §404.002(b) administratively attaches the office to the division, but specifies that the office is independent of the division. For this reason, a request from OIEC does not constitute a request from the division per 28 Texas Administrative Code §134.120(e).

Texas Labor Code §404.101(b)(2)(C) states that OIEC shall "assist injured employees, through the ombudsman program, in the division's administrative dispute resolution system." The division concludes that the injured employee requested the medical narrative with the assistance of OIEC in accordance with Texas Labor Code §404.101(b)(2)(C). Therefore, per 28 Texas Administrative Code §134.120(d), WC Solutions is not responsible for the reimbursement of the service in question.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	October 27, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.